MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Dr. B 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-04-1503-01 TWCC No.: ___ Injured Employee's Name: ___
Respondent's Name and Address Texas Mutual Insurance Co. Box 54	Date of Injury: ___ Employer's Name: ___ Insurance Carrier's No.: 99C0000322434

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
11/02/02	**11/01/02**	**97799-JA (7 units)**	**294.00**	

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 09/05/03 states in part, "…We were originally paid a partial payment for our charge of 97799-JA. According to the EOB the carrier audited our billing as a Physical Performance Exam instead of the correct procedure of Job Analysis. We resubmitted our billing back in requesting a reconsideration based on the above information via certified mail…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary dated 10/14/03 states in part, "… The documentation does not support that a service requiring more skill and work than the above enumerated services, therefore, it is this carrier's position $100 per hour is fair and reasonable. This carrier has received NO information as to how or why $268 an hour is fair or reasonable. TWCC Rule 133.3 requires efficient utilization of healthcare. Please keep in mind no patient care is rendered and part of the time is spent driving…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 97799-JA for date of service 11/01/02 denied as "01, M, YM – The charge for the procedure exceeds the amount indicated in the Fee Schedule and the reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(D). Per the 1996 Medical Fee Guideline, Medicine Ground Rule CPT descriptor this code is considered a DOP code. Per the 1996 MFG, General Instructions (III)(A)(1) the requestor did not submit the Job Assessment report to support services were rendered as billed. Per Rule 133.307(g)(3)(D) the requestor did not submit convincing evidence to support the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with Rule 133.1 and Rule 134.1. Additional reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
11/1/2002	97799-JA	$294.00	$0.00				
					Total Left Column:		$294.00
					Total Amount Due:		$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $48.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster Typed Name	December 22, 2004 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____